Health Home: Medicaid Benefit that Provides Comprehensive Care Management

Health Home is an optional State Plan benefit authorized under Section 2703 of the Affordable Care Act (ACA) to coordinate care for people with Medicaid who have two or more chronic conditions (e.g., diabetes, hypertension, obesity, asthma) or a serious mental illness (SMI) or serious emotional disturbance (SED), complex trauma in children, or HIV). Health Homes have been serving adults since 2012. In December 2016, the Health Home model will begin serving children (individuals under 21).

Health Home is a Care Management model that provides:

- Enhanced care coordination and integration of primary, acute, behavioral health (mental health and substance abuse) services, and
- Linkages to community services and supports, housing, social services, and family services for persons with chronic conditions.

Each Health Home in New York is led by one provider, which has created and oversees a comprehensive network of care managers and other providers to help members connect with:

- Multiple ambulatory care sites (physical and behavioral health, specialty providers for children and adults) and hospital systems;
- Community and social supports, e.g., housing and vocational services; and
- Managed Care Plans that serve Medicaid members.

Health Home enrollment for Medicaid members that meet Health Home eligibility criteria is optional, and members may choose the Health Home they would like to provide them care management services.

Tailoring Health Home Model to Serve Children

The State, including the Department of Health (DOH), OMH, OASAS, and OCFS has worked with stakeholders to tailor the Health Home model to serve children to:

- Expand Health Home eligibility criteria to include complex trauma;
- Incorporate the use of the modified Child and Adolescent Needs and Strengths Assessment-NY (CANS-NY) tool in the model;
- Tailor the delivery of the six core Health Home services to be child focused and family driven and develop standards and policies for Health Homes that will serve children;
- Develop referral and assignment process for enrolling children into Health Home (parental/legal guardian consent requirements);
- Expanded the network requirements of lead Health Homes to include children’s providers, and to incorporate and transition the expertise of care managers that currently serve children under other programs, including Early Intervention, Office of Mental Health Targeted Care Management (OMH TCM), Care at Home I & II and Voluntary Foster Care providers; and,
- Linkages to children’s systems of care (child welfare, education, juvenile justice).